17 Home Health

Medicaid provides home health care services to all Medicaid-eligible persons of any age, who meet the admission criteria, based on a reasonable expectation that a patient's medical, nursing, and social needs can adequately be met in the patient's home.

To be eligible for home health care, a recipient must meet the following criteria:

- The recipient's illness, injury, or disability prevents the recipient from going to a physician's office, clinic, or other outpatient setting for required treatment; as a result, he or she would, in all probability, have to be admitted to the hospital or nursing home because of complications arising from lack of treatment.
- The recipient is unable to leave home under normal circumstances. Leaving home requires a considerable and taxing effort by the recipient, and absences from the home are infrequent, of relatively short duration, and for medical reasons.
- The recipient is unable to function without the aid of supportive devices, such as crutches, a cane, wheelchair or walker; requires the use of special transportation or the assistance of another person.

The patient's attending physician must certify the need for home health services and provide written documentation to the home health provider regarding the recipient's condition which justify that the patient meets home health criteria. The physician must re-certify care every 60 days if home services continue to be necessary. The attending physician must be a licensed, active Medicaid provider.

The policy provisions for home health providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 12.

17.1 Enrollment

EDS enrolls home health providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

To become a home health provider, a provider must be a public agency, private non-profit organization, or proprietary agency primarily engaged in providing part-time or intermittent skilled nursing and home health aide services to patients in their homes. Only in-state home health agencies are eligible for participation in Medicaid.

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National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a home health provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for home health-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Home health providers are assigned a provider type of 5 (Home Health). The valid specialty for home health providers is 050 (Home Health).

Enrollment Policy for Home Health Providers

To participate in Medicaid, home health providers must meet the following requirements:

- Be certified to participate as a Medicare provider
- Be certified by the Division of Licensure and Certification of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation
- Submit a copy of the agency's most recent cost report

For continued participation as a Medicaid home health care provider, an annual Medicare cost report for the home health agency's fiscal year must be submitted to Medicaid within 30 calendar days after the report is submitted to Medicare. A copy of any Medicare audit adjustment or settlement must be submitted to Medicaid within 30 calendar days of receipt by the home health agency.

NOTE:

If the cost report is not provided as required, the home health agency's contract may be terminated for noncompliance.

17.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

17.2.1 Covered Services

Registered Nurse Services (RN)

If ordered by the patient's attending physician, a registered nurse employed by a certified home health agency can provide part-time or intermittent nursing services to a patient.

- The RN is responsible for a nursing care plan, which is made in accordance with the physician's written plan of care.

- Restorative, preventive, custodial and maintenance, and supportive services are covered.

Licensed Practical Nurse Services (LPN)

If ordered by a patient's attending physician, a licensed practical nurse, supervised by an RN employed by a participating home health agency, can provide intermittent or part-time nursing services to the patient when assigned by the RN.

LPN services are provided in accordance with existing laws governing the State Board of Nursing.

Home Health Aide or Orderly Services

A home health aide or orderly can provide personal care and services as specified in the attending physician's plan of treatment.

Supervisory visits by the registered nurse must be performed at least every 60 days when services are provided by the LPN, home health aide, or orderly. These services may be provided on a part-time basis only and must be ordered by the attending physician. The RN who is responsible for the care of the patient must supervise the service.

17.2.2 Noncovered Services

There is no coverage under the Medicaid Home Health Care plan for visits by paramedical personnel, physical therapists, speech therapists, occupational therapists, and inhalation therapists for recipients 21 years of age or older.

Medicaid also does not cover sitter service, private duty nursing service, medical social workers, or dietitians except for recipients under 21 years of age.

Supervisory visits made by an RN to evaluate appropriateness of services being rendered to a patient by an LPN, aide, or orderly are considered administrative costs and may not be billed as skilled nursing services. The registered nurse will provide and document in the case record on-site supervision of the LPN, home health aide, or orderly at least every 60 days. The registered nurse will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the worker.

17.2.3 Visits

A visit is a personal contact in the place of residence of a patient by a health worker employed by a certified Medicaid home health agency for the purpose of providing a covered service.

Home health care visits to Medicaid recipients must be medically necessary and provided in accordance with a Medicaid Home Health Certification form signed by a licensed physician. Home Health records are subject to on-site audits and desk reviews by the professional staff of Medicaid.

If a Medicaid recipient receiving home health visits is institutionalized and is referred to home health upon discharge from the institution, a new Medicaid Home Health Certification form must be completed and retained by the home health agency.

NOTE:

Home health care visits, including nurse aide visits, are limited to 104 per calendar year. Nurse aide visits are restricted to two visits per week.

17.2.4 Medicare/Medicaid Eligible Recipients

Persons eligible for Medicare and Medicaid are entitled to all services available under both programs, but a claim must be filed with Medicare if Medicare covers the services. A patient may not receive home visits under both programs simultaneously. If Medicare terminates coverage, Medicaid may provide visits.

17.3 Prior Authorization and Referral Requests

Therapy services are limited to EPSDT recipients and must be prior authorized. Additional skilled nursing visits and home health aide visits are limited to EPSDT and must be prior authorized once the recipient has exceeded 104 home health visits in a calendar year. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

17.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by home health providers.

17.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Home health providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

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When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

17.5.1 Time Limit for Filing Claims

Medicaid requires all claims for home health to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

17.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

17.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes apply when filing claims for home health services. Include these procedure codes on bill type 33X (Outpatient):

Physical Therapy - Supervised

Revenue Code	*Procedure Code*	*Description*
420	97001	Physical Therapy evaluation
420	97002	Physical Therapy re-evaluation
420	97010	Application of a modality to one or more areas; hot or cold packs
420	97012	traction, mechanical
420	97014	electrical stimulation (unattended)
420	97016	vasopneumatic devices
420	97018	paraffin bath
420	97022	whirlpool
420	97024	diathermy

Revenue Code	*Procedure Code*	*Description*
420	97026	infrared
420	97028	ultraviolet

Physical Therapy - Constant Attendance

Revenue Code	*Procedure Code*	*Description*
420	97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
420	97033	iontophoresis, each 15 minutes
420	97034	contrast baths, each 15 minutes
420	97035	ultrasound, each 15 minutes
420	97036	Hubbard tank, each 15 minutes

Physical Therapy Therapeutic Procedures

Revenue Code	*Procedure Code*	*Description*
420	97110	Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
420	97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
420	97113	aquatic therapy with therapeutic exercises
420	97116	gait training (includes stair climbing)
420	97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
420	97140	Manual therapy techniques, (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
420	97150	Therapeutic procedure(s), group (2 or more individuals)
420	97504	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
420	97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
420	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
420	97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes (requires Prior Authorization)
420	97542	Wheelchair management, propulsion training, each 15 minutes
420	97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

Occupational Therapy - Supervised

Revenue Code	*Procedure Code*	*Description*
430	97010	Application of a modality to one or more areas; hot or cold packs
430	97018	paraffin bath
430	97022	whirlpool

Occupational Therapy - Constant Attendance

Revenue Code	*Procedure Code*	*Description*
430	97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

Occupational Therapy Therapeutic Procedures

Revenue Code	*Procedure Code*	*Description*
430	97110	Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
430	97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
430	97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
430	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
430	97537	Community/work reintegration training (eg, shopping, transportation, money management, a vocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-to-one contact by provider, each 15 minutes

Orthotics

Revenue Code	*Procedure Code*	*Description*
420 or 430	L3650 – L3995	Orthotics
420 or 430	L4205 – L4210	Orthotics repair
420 or 430	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or truck, each 15 minutes
420 or 430	97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
420 or 430	97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

Speech Therapy

Revenue Code	*Procedure Code*	*Description*
440	92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
440	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
440	92620	Evaluation of central auditory function, with report; initial 60 minutes
440	92621	Evaluation of central auditory function, with report; each additional 15 minutes
440	92626	Evaluation of auditory rehabilitation status; first hour
440	92627	Evaluation of auditory rehabilitation status; each additional 15 minutes (list separately in addition to code for primary procedure)
440	92630	Auditory rehabilitation; pre-lingual hearing loss
440	92633	Auditory rehabilitation; post-lingual hearing loss

Other Home Health Services

Revenue Code	*Procedure Code*	*Description*
551	S9124	Nursing care in the home by LPN; per hour
551	S9123	Nursing care in the home by RN; per hour
571	S9122	Home Health aide or CNA providing care in the home; per hour

NOTE:

Claims for Therapy Services (PT, OT, ST) may be span billed. However, providers must indicate on each detail line the date the procedure was performed instead of noting the total number of units.

Billing for Supplies

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Home health providers must enroll as a DME provider to bill for supplies. Supplies may not be billed on a UB-04 claim form.

17.5.4 Place of Service Codes

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Place of service codes do not apply when filing the UB-04claim form.

17.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims With Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

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NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

17.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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